Guide to Chapter 3

CHAPTER 3

Health and Functional Criteria for Service Eligibility[1]

In addition to general coverage criteria required by Federal Medicaid law, states set health and functional criteria to determine who in the large group that is financially eligible will receive home and community services in specific programs. For every Medicaid service, states have to answer two basic questions: (a) how to define medical necessity and (b) how to manage overall utilization. This chapter discusses health and functional criteria for service eligibility with respect to three major Medicaid service categories: the mandatory home health benefit, the personal care option, and HCBS waiver programs.

Introduction

Federal law and regulation specify the general eligibility and coverage requirements for mandatory and optional Medicaid home and community services. States are permitted to use additional service criteria to specify who, within the general eligibility group, will receive services. States use a number of different terms to describe these criteria: health and functional criteria, level-of-care criteria, targeting criteria, and service criteria. These terms are basically interchangeable. This Primer uses the term *service criteria.* How free states are in setting these service eligibility criteria depends on whether the service is Federally mandated or a state option and, if optional, whether it is offered under the state Medicaid plan or through a waiver program.

Service criteria generally include measures of functioning, which are typically defined in terms of everyday activities an individual is unable to perform without assistance because of physical or mental impairment. Such activities can include what are termed Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring from bed to chair, and maintaining continence. IADLs are tasks that require higher cognitive functioning than ADLs, and include activities such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.[2] While IADL performance requires higher cognitive functioning than does ADL performance, assistants who provide help with most IADLs (e.g., shopping, housekeeping) will generally need less training than assistants who provide help with ADLs. This is particularly true when assistance with an ADL requires activities covered by Nurse Practice Acts (e.g., catheterization).[3]

For Federally mandated services (e.g., home health), states may set only two types of service criteria. They may make service eligibility criteria based on medical necessity and they may impose controls on

Federal Coverage and Eligibility Requirements for Medicaid Home Health Services

Examples given by the Office of General Counsel of questions that could be relevant in determining medical necessity

"1. Relation to medical condition: is the service required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy, or is the service required to assist the recipient in activities of daily living?

2. Medical reason for treatment: is the service provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or provider?

3. Clinical appropriateness: is the service consistent (in terms of amount, scope, and duration) with generally accepted standards of good medical practice?

4. Medical need for choice among alternate settings: is the service affording treatment generally provided to similarly situated individuals in the setting, or is there an alternate available setting where, under generally accepted standards of good medical practice, the same service may be safely and effectively provided? In other words, is there a medical need for the service to be provided in a particular setting, such as the home, as opposed to another covered Medicaid service provided in another readily available setting?" Of course, these questions would not apply where the ADA or Medicaid require that the beneficiary have a choice among alternate settings.

utilization. Both these criteria in fact allow considerable leeway, because they are not defined further in Federal law or regulation. The medical necessity limitation is often interpreted as requiring preauthorization—namely, authorization by a medical professional before the service begins—but these services do not have to be *medical* services (see further below).

Controlling utilization is typically understood to mean placing limits on either the number of times a service may be provided, or the period over which it can be provided, for a given condition.[4]

Optional benefits provided under a state's Medicaid plan (e.g., personal care services) carry no Federal statutory or regulatory provisions regarding the type or level of impairment a person should have to receive benefits. The only Federal rule is that the state must make the service equally available to all recipients who satisfy the service criteria that have been set. Within the parameters of the Federal definition of personal care services, for example, states are permitted to choose the measures they use to assess need, and the particular level and/or combination of needs a person must have. For example, one state may require a person to have 2 out of 5 impairments in ADLs. Another might require a person to have 3 out of 12 impairments in ADLs and IADLs. This freedom has resulted in considerable variation in states' personal care service criteria.

Designing Medicaid service criteria can be a major challenge for states, because competing policy objectives are involved. On the one hand, states want to ensure that service criteria identify all individuals who have legitimate needs for assistance. On the other hand, states must operate their Medicaid programs within financial constraints set by their state budgets. Since the number of people served is a major determinant of total program costs (the other being cost of the service), setting service criteria is a fundamental component of state financial decision making.

The complications implied by the tradeoff between coverage and costs can arise through unintended effects on other parts of the long-term care system. Take, for example, the issue of setting service criteria for nursing home admission. Since long-term care services delivered in an institutional context are extremely expensive, a state may wish to require applicants to meet stringent criteria of medical need or have a severe level of functional limitation. Supporting home and community services through an HCBS waiver program can be considerably less expensive. But Federal law requires that the service criteria a state sets for HCBS waiver applicants be the same as those applied to nursing home applicants. Stringent institutional criteria can be an obstacle to serving people in HCBS waivers, because some people who meet the criteria may be too impaired to be cared for safely and cost-effectively in the community unless they have extensive informal help. Very stringent service criteria may also result in premature institutionalization, if informal care networks "burn out" because

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The mandatory home health services are: (a) nursing services provided on a part-time or intermittent basis by a home health agency that meets requirements for participation in Medicare; (b) home health aide services provided by a home health agency that meets requirements for participation in Medicare; and (c) medical supplies, equipment, and appliances suitable for use in the home. The optional home health services are physical therapy, occupational therapy, and speech pathology and audiology services.

- All services offered under the home health benefit are mandatory for all Medicaid beneficiaries entitled to nursing facility services under a state plan. This includes (a) categorically eligible persons age 21 and over, (b) persons under age 21 if the state plan provides nursing facility services for them, and (c) medically needy persons if the state plan provides nursing facility services for them.
- Services must be ordered by a physician as part of a written plan of care that the physician reviews every 60 days.[5]
- Services must be provided at the recipient's place of residence, which does not include a hospital, nursing facility, or ICF/MR.
- Eligibility of beneficiaries to receive home health services does not depend on their need for, or discharge from, institutional care.
- States may place coverage limits on home health services if the limits are based on considerations related to medical necessity or utilization control.

paid assistance is not available until a person is severely impaired.

Alternatively, states may decide they would rather serve more people and control utilization (and therefore costs) by limiting the amount of services provided. The problem here is that the more restrictions the state imposes on the amount, scope, and duration of services, the more likely it is that people with significant needs will be inadequately served in the community and end up in an institution—with substantially increased costs to the state.

There is no "correct" decision regarding service criteria. An approach that is appropriate in one state may not work in another. Each approach has tradeoffs and, as with most Medicaid decisions, each state's tradeoffs will vary depending on its unique service system. This underscores the need to make decisions about service criteria within the broader context of a state's long-term care system—which includes both institutional and home and community services and, with respect to the latter, several alternative funding streams.

States use various approaches to ensure that the service criteria for each program within its long-term care system not only match the policy goals for that program but also fit into the larger system. Several states achieve the combination of goals by using an assessment process that starts with an eligibility determination for the highest level of need—nursing facility/waiver services. If applicants do not meet the nursing facility level-of-care criteria, they are then considered in succession for other long-term care programs that have progressively lower need requirements. The waiver program may require three ADL limitations, for example, but the state-funded personal care program may require only two.

The remainder of this chapter provides information about Federal provisions related to the selection of service criteria for three home and community benefits: home health services, personal care state plan services, and waiver services. These three benefits account for the vast majority of Medicaid spending on home and community services. While similar services may be covered by all three benefits (e.g., assistance with ADLs), the three benefits differ in major respects. First, and most importantly, home health services are mandatory; the other two are optional. Second, home health services require physician authorization; the other two do not. Third, waiver beneficiaries have to meet institutional level-of-care criteria; home health and personal care beneficiaries do not.

Home Health Services

Home health services are a mandatory benefit for all individuals entitled to nursing facility care under a state's plan.

To receive home health services, Federal regulations specify that the services must be ordered by a physician as part of a written plan of care. Beyond this authorization procedure and the general requirement that services be medically necessary, a person is required to meet no additional Federal requirements in order to receive home health services.

Misperceptions

Misperceptions are common, however, that additional Federal requirements do further restrict who may receive home health services. First, many assume that individuals must be *eligible* for nursing facility care in order to receive home health services (i.e., that they must meet a state's nursing facility level-of-care criteria). This misunderstanding has most likely arisen because people have misinterpreted the word *entitled* to nursing facility care to mean *eligible* for nursing facility care. The Federal requirement specifies only the minimum coverage group and does not require that the individual meet a nursing facility level of care (i.e., be eligible). Second, it is widely but incorrectly believed that states must use Federal eligibility requirements for the *Medicare* home health benefit to determine eligibility for Medicaid home health services.[6] In particular, many incorrectly believe that to be eligible for Medicaid home health services, a person must meet the *Medicare* requirements of being homebound and in need of skilled services.

In fact, states *may not limit* Medicaid home health services to individuals who require skilled services as defined by Medicare (i.e., skilled nursing and therapy services).[7]

Additionally, while Federal regulations state that home health services must be provided in the home, there is no requirement that the beneficiary be homebound. Indeed, as a recent letter from HCFA to State Medicaid Directors clarifies, a homebound requirement violates Medicaid comparability requirements.[8] (See Appendix II for the complete text of this letter.)

Medicaid home health services must be provided by Medicare-certified home health agencies. This requirement does not create a linkage between the two programs, however. Federal Medicaid policy permits states to provide home health services to persons with a wider range of needs than is possible through the Medicare program.

Ways to Address Cost Concerns

States can address cost concerns without using the impermissible homebound criterion. For example, instead of using a blanket homebound requirement, a state may set limitations based on medical necessity, which take account of beneficiaries' unique needs (consistent with the Office of General Counsel examples quoted earlier in this chapter). Colorado's home health regulations provide a good example of how the provision of home health services can be limited to appropriate situations without instituting a homebound requirement (see box).

States can also control costs for the home health benefit by limiting the amount, scope, and duration of home health benefits—as long as all services in the state plan category are sufficient to meet the needs of most persons who need the services. For example, some states limit the number of home health visits to no more than one visit per day, combined with exceptions based on preauthorization. Others require preauthorization for additional visits or for more than four hours of service per day. And some states have blanket preauthorization requirements to ensure appropriateness.

For states that have capitated Medicaid health care benefits, and have provided contracts to private managed care organizations to provide those benefits, the extent of the home health benefit needs to be specified with particular care. The situation in Tennessee, where recent reductions in capitated home health benefits have resulted in a lawsuit, provides a good example of the issues raised. Prior to capitation of the home health ben-

Colorado's Coverage Criteria for Home Health Benefits

Rather than instituting a blanket homebound requirement, Colorado's regulations state that home health services will be covered under the following specific circumstances: "When the only alternative to home health services is hospitalization or the emergency room; OR the client's medical records accurately justify a medical reason that the services should be provided in a client's home instead of a physician's office, clinic, or other outpatient setting, according to one or more of the following guidelines:

1. When the client's condition prevents him/her from going to another health care setting to obtain the service, such as a client with quadriplegia who needs aide services to get in and out of bed;
2. When going to an outpatient setting for the service would constitute a medical hardship due to the client's condition;
3. When going to an outpatient setting for the needed service is contraindicated by the client's documented medical condition, such as a client who must be protected from exposure to infections;
4. When the client's medical condition requires teaching that is most effectively accomplished in the client's home on a short-term basis;
5. When going to an outpatient setting for the service would interfere with the effectiveness of the service. Examples include: (1) when hours of travel would be required; (2) when services are needed at a frequency that makes travel extremely difficult, such as IV care three times a day; (3) when a client needs regular and unscheduled catheter changes, and having home health in place will prevent emergency room visits for unscheduled catheter changes due to blockage or dislodgment; (4) when there is a history of noncompliance with outpatient services that has led to adverse consequences, including emergency room use and hospital admissions.
6. When a client is unable to perform the health care task him/herself, and has no unpaid family/caregiver able and willing to perform it."

efit in 1993, Tennessee limited home health services to 60 visits per year and required beneficiaries to be "homebound." When HCFA granted an 1115 waiver creating TennCare, home health services were among the benefits covered by the capitation rate. One of HCFA's waiver conditions was removal of the homebound requirement and the limit on number of home health visits. The state agreed to these provisions and promulgated consistent regulations.

In 1997, however, the managed care organization providing Medicaid's home health services in the state sought to exclude all "custodial" services from their contract, and to require home health beneficiaries to meet the same definition of medical necessity that the organization uses for its commercial market enrollees. This definition requires home health users to be homebound and excludes coverage for beneficiaries who require care on a "custodial" basis or over a long period. Disabled beneficiaries not meeting the new definition are directed to nursing homes—at greater cost to the state but reduced cost to the plan. A lawsuit was subsequently brought to bar the state from continuing to deny medically necessary home health services to TennCare members and from requiring disabled TennCare beneficiaries to be placed in nursing homes in order to receive services.

The general issue for states is how to ensure that managed care contracting does not result in denial of necessary services to beneficiaries. Clearly, when home health benefits are included in a managed care contract, the contractor has an incentive to restrict provision of such benefits in order to contain costs. To guard against this potential, it is very important for states to specify in their managed care contracts *who* will determine eligibility for home health benefits and *what* service criteria will be used. Clear and precise terms are crucial. Eligibility criteria that are framed in very general terms—*medical necessity*, for example—can be

Unresolved Issue: Provision of Services Outside a Beneficiary's Home

A Connecticut lawsuit challenged HCFA's regulation requiring that Medicaid home health care services be provided exclusively in a beneficiary's place of residence.

The Court of Appeals ruled that the Medicaid statute is ambiguous with respect to whether home health care services must be provided exclusively at the recipient's residence.[9] Specifically, the court ruled that "the Medicaid statute neither allows nor prohibits reimbursement for home health services outside the recipient's residence. The statute merely provides that states may include 'home health care services' in their Medicaid programs. 42 U.S.C. Section 1396d(a)(7).[10] It does not define home health care services, and though the statute implies that the services will normally be rendered in the home, neither the context of the provision nor the structure of the statute indicates whether the home is the exclusive locus of the necessary services."

The court went on to hold that "the regulation as written is invalid," because the restriction of home health care services to a recipient's residence "ignores the consensus among health care professionals that community access is not only possible but desirable for disabled individuals." The court further stated that the assumptions behind the restriction of services to the recipient's residence were medically obsolete, and that "the technology and knowledge now exist to allow many people with disabilities, elderly or not, to venture into the community, where before they would have been considered permanently homebound."

To ensure that the ruling would not result in increased costs for the state, the court expressly limited recipients of Medicaid-covered home health nursing services to the number of hours of services to which they would be entitled *if the services were provided exclusively at the recipient's place of residence*.

The Second Circuit ruling affects only the three states in its jurisdiction: Connecticut, Vermont, and New York. HCFA is currently reviewing a request to change its regulation to be congruent with the Court's ruling. Such a regulatory change would generalize the substance of the Court's decision to apply to all states.

interpreted very differently in a managed health care plan that customarily provides acute care benefits than in a state plan designed to provide long-term care services.

The appropriate context for making decisions about limits on home health benefits, as noted, is the whole state system of home and community coverage. A state may opt to cover a very limited number of registered nurse and home health aide visits through the home health benefit, for example, but provide additional coverage for those with greater needs through its waiver program. (This leaves any additional service needs of individuals not eligible for waiver services unmet, of course. Chapters 4 and 5 discuss in detail the factors to consider when making such coverage decisions.)

Personal Care Option

Personal care services provided through the state plan are an optional benefit. When personal care services were first authorized, services had to be prescribed by a physician in accordance with a plan of treatment. In 1993, Congress removed the requirement for physician authorization and gave states the option to use other methods to authorize benefits in accordance with a service plan approved by the state. There are no other Federal statutory or regulatory requirements regarding coverage under the personal care option. Nor are there guidelines for minimum or appropriate service criteria. Within the broad parameters of the Federal definition of personal care services, states are free to determine criteria for service eligibility as well as the amount, scope, and duration of the benefit.

In the absence of prescriptive requirements for service criteria, the Federal definition of personal care services becomes the primary guide for establishing service criteria. The State Medicaid Manual defines the scope of personal care services as:

> "a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables them to accomplish tasks they would normally do

> for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs)."[11]

Persons with cognitive impairments can also be offered services through the personal care option. As the Medicaid Manual states:

> "An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cueing along with supervision to ensure that the individual performs the task properly."[12]

Given the Federal Medicaid definition of personal assistance, it follows that appropriate service criteria should be based on a need for assistance with ADLs or with IADLs. There is a considerable body of research on ADLs and IADLs to guide states in designing their service criteria. Generally, ADLs are more frequently used than IADLs to determine service eligibility, because they are widely believed to measure a greater level of need. But a number of states use both ADLs and IADLs in their service criteria. This is consistent with research showing that dependencies in multiple IADLs also indicate a high level of need.[13] Limitations in performing some IADLs, such as meal preparation and medication management, may actually pose a greater health risk than an ADL limitation in bathing and dressing. Recent research has shown, for example, that inability to use the telephone actually indicates a very high level of impairment.[14]

An important consideration when selecting service criteria is that the level of impairment required for eligibility match the services covered. For example, if a state requires applicants to be severely impaired, the maximum number of service hours permitted should be sufficient to enable such people to remain in the community even if they have little informal care. Otherwise, requiring too high a level of impairment could prevent those without informal care from receiving necessary services.

It is also important to ensure that assessment and authorization methodologies do not inadvertently exclude certain categories of potential beneficiaries, such as persons with cognitive impairment. Failure to include criteria that measure the functional limitations relevant to these individuals—such as the need for cueing to perform ADLs—can lead to their exclusion. States may be inadvertently making such exclusions. Even though 26 states offered personal care services in their state plans, for example, a survey of state agencies serving persons with developmental disabilities found that services through the personal care option play little or no role in paying for long-term services for this group.[15]

Historically, Michigan used to be the most noteworthy example of a state that optimized the personal care benefit as a means of funding home and community services for people with developmental disabilities. Michigan built many of its community services on personal care as the baseline core benefit, for example, weaving it into foster home settings and other types of living arrangements. However, in the 1995 amendments to the state's HCBS waiver program for people with mental retardation and developmental disabilities, Michigan started moving to waiver funding of services for these groups.

In effect, states have a very high level of discretion to determine who will receive personal care services through the state plan. However, states may not violate Medicaid comparability requirements by restricting services to those with a particular diagnosis or condition (e.g., by making benefits available only to people with spinal cord injuries or people who use wheelchairs, or to people who are likely to require nursing facility services).

Illustrative Service Criteria for Personal Care Services: State Examples

Massachusetts

To be eligible for personal care services in Massachusetts, Medicaid beneficiaries must have a permanent, chronic disability. The service criteria are specified in terms of hours of assistance needed—rather than type, number, or level of ADL and IADL impairments. Individuals must need a minimum of 10 hours per week of assistance with ADLs, or 14 hours of assistance with a combination of ADLs and IADLs. The average hours for most consumers is 42 per week. The program serves both self- and non-self-directing consumers and allows surrogates to manage services for those who cannot do so themselves.

Massachusetts specifies as ADLs to be assessed all aspects of mobility (walking, transferring, using durable medical equipment); bathing, personal hygiene, and grooming; dressing and undressing; basic exercises such as range of motion; preparation and ingestion of meals and clean up; assistance with bowel and bladder needs; and assistance with medication administration. The IADLs the state assesses are housekeeping, laundry, shopping, ability to make visits to health care providers, and unique needs (e.g., care and maintenance of wheelchairs).

Arkansas

To be eligible for personal care service in Arkansas, a person must have physical dependency needs and require assistance to perform the following tasks and routines: eating, bathing, dressing, personal hygiene, bladder and bowel requirements, taking medications, laundry, incidental housekeeping, and shopping for personal maintenance items.

New York

To be eligible for personal care services in New York, individuals must need some or total assistance with a wide range of tasks connected with daily living, nutritional and environmental support functions, and health-related tasks. The services must be essential to maintain the individuals' health and safety in their own home. Tasks that are considered include bathing, dressing, feeding, grooming, toileting, walking in and outside the home, transferring, meal preparation in accordance with modified diets, medication administration, and skin care. Nutritional and environmental support functions include meal preparation, housekeeping, laundry and ironing, shopping, bill payment, and other essential errands.

Given that personal care services are subject to statewideness and comparability requirements, states understandably have cost concerns about increasing access to these services by using less stringent service criteria, even though they can control costs by limiting the amount, scope, and duration of services. As mentioned at the beginning of this chapter, there is no "correct" decision regarding service criteria. Whether or not particular service criteria are appropriate and make sense depends on the broader context of a state's policy goals for its entire long-term care system (i.e., whether the criteria fit logically into the overall plan for providing services to people with long-term care and support needs through multiple programs).

To ensure that their programs do make sense within their particular service systems, some states design "wraparound" state-funded programs to provide services to people who do not meet either Medicaid's financial criteria or the state's service criteria. The Connecticut Home Care Program for Elders has three levels of service, for example, with Level One and Level Two funded solely with state funds. Level One serves people who meet neither the Medicaid asset test nor the waiver service criteria. Level Two serves people who meet the waiver service criteria but not the asset test.[16] Level Three serves those who meet both financial and service criteria. In this framework, the stringency of the institutional service criteria is not a major issue, because there is an alternative source of services for those who do not meet them.

HCB Waiver Program Services

To be eligible for HCB waiver services, individu-

als must first meet a waiver's targeting criteria, such as age and diagnosis or condition. For example, a state may have a number of waivers targeting different groups: persons age 65 and older, persons ages 18 to 65 with physical disabilities, children who are technologically dependent, persons with mental retardation and other developmental disabilities, persons with AIDS, and persons with traumatic brain injury. (See Chapter 4 for a full discussion of waiver programs.)

Individuals who meet the targeting criteria must then meet service criteria, which for HCBS waiver programs are the level-of-care criteria used to determine eligibility for either a hospital, nursing facility, or ICF/MR. Level-of-care criteria explicitly describe the type and level (or severity) of functional limitations or needs an individual must have in order to be admitted to an institutional setting.

These criteria usually include measures of need for assistance with ADLs and for other services, including nursing and medically related services. A determination that a person meets the required level-of-care criteria is based on information gathered through a formal assessment process carried out when a person applies for services. In the case of ICF/MR services, the person must have mental retardation or a "related" condition and be found to need various supports necessary to improve or maintain functioning. In the case of nursing facility services, the need for skilled and unskilled nursing care is generally assessed, as is the need for assistance with ADLs and other aspects of functioning.

The requirement to use the same or equivalent service criteria for HCB waiver services as for institutional placement stems from the waiver program's primary purpose: to offer an alternative to institutionalization.[17] This is a statutory requirement added by Congress in part to address concern about the cost of expanding HCB services: States must demonstrate that they are providing waiver services only to people who are eligible for institutional placement. HHS cannot waive this requirement or lessen its impact by regulation. Thus, states would only be able to use substantively different service criteria for waiver than for institutional services (i.e., criteria not based on the need for institutional services) if Congress amended Medicaid law.

When the waiver authority was enacted in 1981, home and community services could be provided under a waiver program only to persons who met the level-of-care criteria for *either* an SNF, an ICF, or an ICF/MR. In 1987, the Omnibus Budget Reconciliation Act eliminated the distinction between SNFs and ICFs and mandated a new nursing facility benefit, which included ICF services, all of which were previously optional. The former ICF level of care is now the minimum institutional standard. The only Federal requirement for persons to receive an ICF level of care is that the individuals need either health-related care and services that are above the level of room and board or, due to their mental or physical condition, require supportive services that can be made available only through institutional facilities. Within this broad definition, states are free to set whatever service criteria they choose for nursing facility care, which (or their equivalent) are then used to determine eligibility for waiver services.

Misperceptions

A common criticism of nursing facility level-of-care criteria is that they are "medically biased," that is, (a) they do not adequately assess functional limitations and their impact on the need for long-term care, or (b) they give greater weight to nursing and medical needs than to functional needs. However, no Federal statute or regulation mandates that states adopt this medical approach when setting nursing facility service criteria.

Medicaid law does require that institutional services be medically necessary. But, as noted, there is no Federal definition of this term, and states are free to define it broadly (e.g., medically necessary services are those that promote optimal health and functioning). Thus, the requirement that services be medically necessary does not mean a state is required to use only medical—or even any medical—service criteria to determine eligibility for nursing facility services.[18] Nor must a state give greater weight to medical and nursing needs than to functional needs.

No clear line separates medical from functional

Illustrative Uses of Functional Measures to Determine Eligibility for Nursing Facility and Waiver Services: State Examples

Connecticut

To be eligible for nursing facility or HCBS waiver services in Connecticut, a person must need either hands-on assistance or supervision with three critical needs. The critical care needs that are assessed are eating/drinking, toileting, transferring, bathing, dressing, medication management, and meal preparation. Alternatively, a person must have cognitive impairment and behavioral problems. The determination of critical needs is the central factor in Connecticut's level-of-care determination, but other factors are also considered, including diagnosis, nursing needs, and informal supports.

Indiana

To be eligible for nursing facility or waiver services in Indiana, a person must have either nursing needs or 3 out of 14 functional needs. Functional needs include assistance with eating, mobility, transferring, turning/positioning, dressing, bathing, toileting/continence, daily supervision or assistance to ensure compliance with a prescribed medication regime, and supervision or assistance to maintain safety due to confusion and/or disorientation.

Kansas

Kansas uses a scored instrument to determine eligibility. The functional measures assessed are (a) ADLs: bathing, dressing, toileting, transferring, eating, mobility; and (b) IADLs: such as meal preparation, medical management, telephone use, laundry/housekeeping, shopping, and money management. A person must need assistance with both IADLs and ADLs. Several risk factors are also assessed: impaired cognition; incontinence; falls; lack of informal support; and abuse, neglect, and exploitation. Because the instrument is scored and the measures are weighted, several combinations of functional need and risk can equal the required score. For example, a person with memory problems and impaired decision making who needs supervision with two ADLs and assistance with three IADLs would be eligible.

needs. Health status and functioning are closely interrelated; immobility due to paralysis or even frailty can lead to serious medical problems in multiple body systems. Thus, failure to address functional limitations can result in serious medical problems that require not only nursing home care, but hospitalization as well. The primary reason people need long-term care services is because they have functional limitations. Even if people require specialized health care (e.g., for injections or catheterization), research has shown that people can meet these needs themselves if they are not physically or mentally impaired. Thus, the single most important measure of need is what functional limitations a person has.

For ICF/MR placement, all states use functional measures in their level-of-care criteria. Kansas determines eligibility for either ICF/MR or HCBS waiver services, for example, with an evaluation instrument called the Developmental Disabilities Profile (DDP). The DDP measures the extent to which a person is able to carry out certain life activities or might need services to address various needs (e.g., medical needs or behavioral issues). Other states use alternative instruments (e.g., the Inventory for Client and Agency Planning, ICAP), or specify other types of assessments that must be conducted to determine the need for assistance in various functional domains.

Another common misperception about Medicaid level-of-care criteria is that an institutional standard requires a severe level of medical need or functional limitation. There is no such Federal requirement. However, states are concerned that making their institutional level-of-care criteria less stringent will result in many more people being eligible for (and placed in) nursing facilities. But research shows that the overwhelming majority of persons with long-term care needs would rather be served in the community. And people who do not want to go to a nursing home are unlikely to change their minds just because the bar for nursing home eligibility has been lowered. The same is true for people with mental retardation or devel-

opmental disabilities.[19] Stringent criteria have unintended effects on HCBS waiver programs, such as limiting assistance states can provide to those who need only a small amount of help to remain in the community.

However states define their nursing home level-of-care criteria, many people who meet those criteria will remain in the community, even without formal services. A recent study in Connecticut, for example, found that many persons with severe functional limitations (three or more ADL impairments), who met the nursing facility level-of-care criteria, chose to go without nursing home or HCB waiver services rather than spend down to Medicaid eligibility or be subject to estate recovery provisions. (Most of the people interviewed in that study were able to remain in the community because they had extensive informal care supplemented by small amounts of privately paid care.)[20]

States' concerns about increasing the number of people admitted to nursing facilities are understandable. However, this effect can be minimized, if not avoided completely, if states initiate steps to screen persons *prior to nursing facility admission* to determine whether services could be provided in home and community settings. Oregon and Colorado are examples of states that have pursued this strategy successfully. Implementation of such programs (called nursing home diversion programs) to ensure that as many people as possible are served in home and community settings—whether through services in the state plan, the personal care option, or waiver—will help ensure that only those who truly cannot be served safely and cost-effectively in the community will be admitted to nursing facilities.[21]

Availability of HCB services can and does reduce the demand for institutional services. The best evidence of this phenomenon is found in the mental retardation / developmental disabilities sector, where, since the advent of HCBS waiver programs, (a) the number of individuals served in large public institutions has declined (from 128,000 in 1980 to under 50,000 in 1999), and (b) the total number of individuals served in large institutional ICFs / MR of all types (public and private) dropped by more than 40 percent between 1982 and 1998.[22] The most important likely result of broadening institutional eligibility criteria is that states are able to furnish important services and supports to individuals in the community, which will help them remain independent and enjoy a better quality of life.

With regard to states' concerns about induced demand (large numbers of persons who would never have gone to a nursing home applying for home and community services once they are available), caps on waiver enrollments enable states to control utilization and overall outlays. This explains in part why every state operates HCBS waiver programs but only about half cover personal care services through the state plan.

Major Considerations in Setting Service Criteria: A Recap

Federal policies with respect to service criteria establish a framework within which states have wide latitude to chart the course of action that best suits their unique long-term care service system.

Three considerations, in particular, should guide state choices in setting their service criteria:

- Service criteria should be developed with an eye toward the full constellation of services and supports a state offers, whether through the Medicaid program or via other state and local resources. In other words, criteria should not be crafted for specific programs without considering the criteria for other long-term care programs in the state. The criteria should fit together so that all individuals needing long-term care services in the state are able to obtain the particular services appropriate to their needs.

- It is important to recognize that there is a constant tug-and-pull among state policy aims. On the one hand, states desire to make services and supports broadly available. On the other hand, states must manage their budgets. Sometimes states impose service criteria for cost-containment reasons, whose stringency undermines the state's ability to promote appropriate access. Careful management of different com-

ponents of the benefit package and establishment of an efficient service delivery system can help a state to work its way between these potentially conflicting objectives.

- Concern that using less stringent criteria—especially with respect to the waiver/institutional eligibility connection—will result in higher demand for (and spending on) institutional services seems to be misplaced. Broader eligibility criteria have been shown to enable a state to obtain Federal financial participation to provide HCB waiver services to a greater number of individuals with substantial impairments, without experiencing an increase in requests for nursing facility and other institutional admissions. Experience confirms that most consumers want to remain in their homes and in the community. Their ability to do so is strengthened through the provision of HCB services.

Endnotes

1. The primary contributors to this chapter are Janet O'Keeffe and Gary Smith.

2. The ADL and IADL scales are based on a developmental model: children learn to eat, toilet, bathe, and dress themselves before they develop the mental ability to do more cognitively complex activities such as using the telephone and managing money. When cognitive abilities start to deteriorate (as in a person who develops dementia) the ability to perform activities that require more complex mental functioning (IADLs) is generally lost before the ability to perform ADLs. In fact, states are not bound by the definitions implied by this developmental model. States are free, for example, to define ADLs as whatever tasks/activities they consider important to define a need for long-term care.

3. Assistants who work with individuals who have cognitive impairments or behavior issues need specialized training.

4. States are permitted to make provision for "outliers"—those individuals whose condition responds less well than expected to the services for their condition, and who, as a consequence, may receive more services for a longer period.

5. The frequency of further physician review of a beneficiary's continuing need for medical equipment and supplies is determined on a case-by-case basis, based on the nature of the item prescribed.

6. Some states link their Medicaid home health benefit with the Medicare benefit through state statutes and/or regulations. A number of states also tie their Medicaid reimbursement methods directly to the Medicare home health reimbursement methods. Harrington, C., LaPlante, M., Newcomer, R.J., Bedney, B., Shostak, S., Summers, P., Weinberg, J., and Basnett, I. (January 2000). *Review of Federal statutes and regulations for personal care and home and community based services: A final report*. San Francisco: University of California, Department of Social and Behavioral Sciences.

7. 42 CFR 440.230(c) and 42 CFR 440.240.

8. 42 CFR 440.240.

9. *Skubel v. Fuoroli*. (No. 96-6201). United States Court of Appeals, Second Circuit. Decided May 13, 1997.

10. When Medicaid was first enacted in 1965, coverage of home health services was optional. In 1970, Congress made coverage of home health services mandatory for those entitled to skilled nursing facility services.

11. State Medicaid Manual, Part 4—Services, Section 4480.

12. State Medicaid Manual, Part 4—Services, Section 4480.

13. Kassner, E. and Jackson, B. (1998). *Determining comparable levels of functional disability*. Washington, DC: AARP Public Policy Institute.

14. Spector, W.D. and Fleishman, J.A. (1998). Combining activities of daily living with instrumental activities of daily living to measure functional disability. *Journal of Gerontology*. 53B: S46-S57.

15. Gary Smith, Director of Special Projects, National Association of State Directors of Developmental Disabilities Services. Personal communication, March 12, 2000.

16. Eligibility rules for Level One and Level Two of the Connecticut Home Care Program for Elders allow applicants to retain up to $16,392 in assets. Allowable income is the same for all three levels: $1500 per month. Cost sharing based on income is required.

17. States may use different evaluation instruments and processes for determining eligibility for HCBS waiver services than for institutional placement as long as they can explain in their waiver application how and why they differ and also provide assurances that the outcome of a different assessment instrument or process is

"valid, reliable, and fully comparable to the forms used for hospital, nursing facility or ICF/MR placement." See Section 4442.5(B)(5) of the State Medicaid Manual.

18. For reimbursement purposes, many states distinguish between those who need a skilled level of care and those who need lower levels of care; others use case mix reimbursement. The need for medical and skilled nursing services is always assessed when determining if a person needs a skilled or high level of care. It is when assessing applicants for ICF or minimal levels of care that states differ widely in the measures they use—some using functional measures only, some nursing measures only, and most a combination of both. O'Keeffe, J. (1996). *Determining the need for long-term care services: An analysis of health and functional eligibility criteria in Medicaid home and community based waiver programs.* Washington, DC: AARP Public Policy Institute.

19. Gary Smith, personal communication, May 11, 2000.

20. O'Keeffe, J., Long, S.K., Liu, K., and Kerr, M. *How do they manage? A case study of elderly persons functionally eligible for Medicaid waiver services but not receiving them.* (1999). Washington, DC: AARP Public Policy Institute.

21. In a study of 42 states' nursing facility level-of-care criteria, respondents in states that used less stringent criteria said that most beneficiaries with lower levels of need could be safely served in the community. O'Keeffe, J. (1996). *Determining the need for long-term care services: An analysis of health and functional eligibility criteria in Medicaid home and community based waiver programs.* Washington, DC: AARP Public Policy Institute.

22. Smith, G. *Medicaid long term services for people with developmental disabilities.* (2000). Alexandria, VA: National Association of State Directors of Developmental Disabilities Services.

Annotated Bibliography

Tonner, M.C., LeBlanc, A.J., and Harrington, C. (March 2000). *State long term care screening and assessment programs*. San Francisco: University of California. (36 pages)

This study of state screening and assessment programs reports data collected by a telephone survey of state officials in all 50 states and Washington, D.C. It examines several features of screening and assessment programs, including coordination across multiple long-term care programs, and the use of uniform need criteria, standard assessment tools, and automated databases. *The document may be ordered for $5.00 by e-mail at sbs@itsa.ucsf.edu or by calling (415) 476-3964.*

O'Keeffe, J. (March 1999). *Elderly persons with cognitive and other mental impairments: Can they meet Medicaid level-of-care criteria for nursing homes and for home and community based waiver programs?* Pub. #9704, Washington, DC: AARP, Public Policy Institute. (40 pages)

This study investigates whether persons ages 65 and older, with functional limitations caused by cognitive and other mental impairments, can meet states' Medicaid level-of-care (LOC) criteria for nursing home and home and community based services waiver programs. A review of 42 states' Medicaid LOC criteria found that persons with cognitive and other mental impairments may find it difficult to be eligible for long-term care services in many states. The report includes a state-by-state description of Medicaid LOC criteria relevant for persons with cognitive and other mental impairments. *To obtain a free copy of this document, contact AARP's Public Policy Institute at (202) 434-3860 or search their website at www.research.aarp.org.*

O'Keeffe, J. (December 1996). *Determining the need for long-term care services: An analysis of health and functional eligibility criteria in Medicaid home and community based waiver programs*. Pub. #9617, Washington, DC: AARP, Public Policy Institute. (113 pages)

This report provides, through text and tables, an overview and comparison of the criteria that 42 states use to determine eligibility for nursing home and home and community based services waiver programs. *To obtain a free copy of this document, contact AARP's Public*